

# Correspondence

*The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.*

## Nonfluoridated Water Used in Manufacture of Infant Formulas

TO THE EDITOR: We recently read the article "Preventable Dental Disease" by Peter Rank and co-workers in the October 1983 issue.<sup>1</sup> We are concerned that readers may be misinformed by the statement "the increasing use of infant formulas with high fluoride content . . .," and we wish to provide additional information on this subject.

The Infant Formula Council represents the manufacturers of infant formula in the United States. Member companies voluntarily decided in 1979 to manufacture infant formulas with nonfluoridated water based on recommendations of the American Academy of Pediatrics Committee on Nutrition.<sup>2</sup> Before 1979 there were various levels of fluoride in different infant formulas on the market, depending on whether they were manufactured with fluoridated or nonfluoridated water. Since the fluoride content of local water supplies varies considerably, the use of nonfluoridated water in the manufacture of infant formula allows physicians to regulate individually an infant's fluoride intake based on fluoride levels in the community water supply. Physicians can now be certain that infant formulas contain an insignificant quantity of fluoride and can safely be mixed with fluoridated water or given with a dietary fluoride supplement as medically indicated.

ROBERT C. GELARDI  
Executive Director  
Infant Formula Council  
Atlanta

### REFERENCES

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2. American Academy of Pediatrics, Committee on Nutrition: Fluoride Supplementation: Revised Dosage Schedule. *Pediatrics* 1979 Jan; 63: 150-152

## More on Herpes Zoster

TO THE EDITOR: As a practicing anesthesiologist for 40 years, and a specialist in pain management for the past 10 years, I am writing you in regard to the article "Clinical Aspects of Herpes Zoster" published in the November 1983 issue.<sup>1</sup>

Herpes zoster is, in my opinion, the most poorly treated disease in the practice of medicine. Why? Because the medical public, in general, is uninformed about the ideal treatment of herpes zoster pain, the most distressing symptom of this disease. The Novem-

ber article does not help in this regard. The author, Dr Glaser, does not even mention the one treatment that eradicates this pain. He obviously is unaware of it.

Conservative management consisting of corticosteroids, analgesic medication and local application of anesthetic ointment is ineffective in relieving the severe pain of herpes zoster.

Analgesic blocking has proved to be the most efficacious method of managing herpes zoster. Injection of the sympathetic and somatic nerves supplying the region involved, early in the disease—that is, within 30 days of the onset, will do three things: It will give the patient complete pain relief, it will shorten the duration of the illness and the skin eruption by 50% and most important it will prevent postherpetic neuralgia.

Only with this kind of therapy will herpes zoster give up its ranking as the most poorly treated disease in medicine.

Pain is the most important and common symptom in our treatment of human beings. Frank Moya, an internationally known professor of anesthesiology, states that at his Pain Center at the Mount Sinai Medical Center in Miami Beach, one of the largest private practice outpatient pain clinics in the United States, herpetic neuralgia is the second most common and difficult pain problem to treat, surpassed only by back pain.

Throughout the many years that I have been practicing pain management, I have seen innumerable cases illustrating the sad lack of medical information regarding the pain management of herpes zoster. Only by the correction and addition to such articles as "Clinical Aspects of Herpes Zoster" and by publishing more articles regarding the ideal treatment of this disease will we give our patients proper treatment.

ARAM FRANKLIN, MD  
Los Angeles

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1. Glaser RB: Clinical aspects of herpes zoster (Topics in Primary Care Medicine). *West J Med* 1983 Nov; 139:718-720

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TO THE EDITOR: Having recently recovered from herpes zoster and having a personal knowledge of a fairly large number of patients with this disease (mostly pediatric, it is true), I have some difficulty understanding Dr Engel's letter regarding herpes zoster neuralgia in the February issue.<sup>1</sup>

Unless he does a double-blind controlled study, his treatment schedule appears to have no validity. If I

had received his therapy I too could say it did wonders for me, but I used a less painful and probably much less expensive method—nothing.

KEITH E. VINCENT, MD  
Vallejo, California

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## Sensitivity to Contact Lens Solutions

TO THE EDITOR: Many patients with allergic rhinoconjunctivitis are unable to wear contact lenses. This problem is frequently assumed to be due to an aggravation of their allergic problem. A case of thimerosal sensitivity is presented, which may indicate the possibility that a sensitivity to thimerosal and a contact dermatitis should be considered in allergic patients unable to wear contact lenses.

### Report of a Case

A 37-year-old woman had had hay fever, urticaria and recurrent otitis media as a child. Aspirin sensitivity with generalized angioedema first developed when she was 19. Asthma was first noted at age 21 and development of nasal polyposis at age 32.

A full allergy evaluation was done at age 32. It showed a large number of very small reactions to the airborne allergens. No environmental allergies were identified. She was treated symptomatically with oral bronchodilators, nasal beclomethasone dipropionate spray and antibiotic therapy when needed for acute sinus infections.

The patient presented at age 36 with inability to wear contact lenses because of severe eye itching and inflammation. She tried both the hard and soft contact lenses without success. Although she experienced minimal eye discomfort when wearing regular glasses, a severe itchy, painful conjunctivitis would occur within two to three hours of wearing her contact lenses. Because of the pronounced exacerbation of her very mild conjunctivitis, the patient was patch tested for thimerosal and ethylenediamine. She had a notably positive reaction to thimerosal at 24 and 48 hours, with negative reactions to both control and ethylenediamine. The patient changed from her wetting solution containing thimerosal to one that contained a different preservative. She subsequently has been able to wear her contact lenses for long periods with no eye irritation.

### Discussion

Inability to wear contact lenses is a frequent complaint encountered in an allergist's office and is often assumed to be related to the patient's allergies. A recent check of available wetting solutions showed most solutions contained thimerosal.

Thimerosal (Merthiolate) is an organic mercurial that is used both as a preservative and a bacteriostatic agent. It is poorly absorbed and tends to fix to the tissues.<sup>1</sup> Patients can have hypersensitivity reactions to either the mercurial or the thiosalicylate portion of the

thimerosal molecule.<sup>2</sup> Tincture of Merthiolate (Lilly) also contains ethylenediamine and a number of azo dyes, all of which can be sensitizing agents.<sup>3</sup>

Discussion with several ophthalmologists indicates that in approximately 10% of their patients fitted with contact lenses, some intolerance to the wetting agent developed. This would be in agreement with a study that showed a high incidence of patch-test-positive reactions to Merthiolate in adults with no previous or current skin disease.<sup>4</sup> This case seemingly indicates that wetting solution sensitivity should be considered in allergic patients who are unable to wear contact lenses due to eye irritation.

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Chula Vista, California

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3. Fisher AA: The use of patch testing in allergic contact dermatitis, chap 3, *Contact Dermatitis*. Philadelphia, Lea and Febiger, 1973, pp 25-70
4. Hansson H, Möller H: Patch test reactions to merthiolate in healthy young subjects. *Br J Dermatol* 1970 Sep; 83:349-356

## Have You Hugged Your Colon and Rectal Surgeon Lately?

TO THE EDITOR: A doctors' parking lot may seem an unlikely place for serious humor, but clearly it has its funny side. Consider the title of this letter for instance—a question seen recently on a bumper sticker in the lot. Or license plate tags like SYNAPSE and WHEEZE. Or PQRSTU. Yes, PQRSTU, in the middle of the alphabet. Not until its electrocardiographer author emerged did this little riddle reveal its secret.

These comic license tags give specialists identity and since we all strive for some uniqueness, we enjoy the playful touch of ego. But let's go back to the bumper sticker, for it carries an illustration of the use of humor in medical practice. While the license tags tickle our fancy, the anal/hug humor penetrates to a deeper level, even to a glimpse of serious insights. In this sense, humor and laughter can serve as powerful therapeutic adjuvants.

Hug your proctologist? In this image suggesting filth, stench, pain and mortification, we are to embrace, to hug? It is laughable. Fortunately that is what we do, that is how we handle it; we laugh at our painful predicament—together. It is therapeutic to know that—to know that we are all in this together. The laugh signals recognition of our mutual plight, for we all have animal bodies with anuses and we're stuck with them. We have to accept the givens of these biological necessities.

But the funny thing is that the comic line also tells us to test the limits of our possibilities, our hugs—even to the unlimited possibilities of love. Humor juxtaposes the necessities with the possibilities. It acknowledges our limits but encourages us to test them. So in medicine it encourages healing.

To come at this with a metaphor from an adjacent specialty, physicians serve as midwives helping people get their spirits reborn. Our very presence as medical